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ABSTRACT

The Tennessee Department of Mental Health and Mental Retardation adopted the Re-ED model for its five residential treatment centers serving severely emotionally disturbed children and adolescents. Procedures for adopting the model are traced, and specific difficult areas in implementation are discussed. It is explained that there is an emphasis on learning appropriate social behaviors and improving social competence: that children and teacher counselors work together in small groups that develop special identities and rituals: that teaching and learning are viewed as change agents rather than psychodynamic interventions: that specific, achievable goals provide frequent opportunity for reinforcement: and that change in each child's own, or intended, ecological setting is considered an essential part of every treatment plan. A 2 year followup study indicated that children benefited from the treatment. (SBH)

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Tennessee Re-ED: From Innovation to Establishment*

W. W. Lewis

The Tennessee Department of Mental Health and Mental Retardation adopted the Re-ED model for operation of its five residential treatment centers serving severely emotionally disturbed children and adolescents in the State. Each center serves a geographical region to minimize distance of children from families and communities, the regions being determined by the service area of the Mental Health Institute (formerly psychiatric hospitals) of which each children and youth program is a part. It would be inaccurate to characterize all of the programs as replications of the model developed at Cumberland House, though all have been greatly influenced by the Re-ED model. With one exception, to be noted later, a visitor to any of the programs would recognize the similarity in staffing patterns, organization, and activities that characterize a Re-ED school. The children and adolescents think of themselves and, for the most part, behave like students in a school. Most of the staff think of themselves and behave like teachers. There is an emphasis on learning appropriate social behaviors and improving competence; children and teacher-counselors work together in small groups that develop special identities and rituals; teaching and learning are viewed as change agents rather than psychodynamic interventions;

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specific, achieveable goals provide frequent opportunity for reinforcement; and change in each child's own, or intended, ecological settings is considered an essential part of every treatment plan.

The decision to initiate replications was made in 1966, four years after the opening of the first Re-ED schools, which was, incidentally, prior to the completion of any serious evaluation studies, so it must be acknowledged that the decision was based on the face validity of the program rather than any evidence of efficacy. There was, of course, the continuing pressure from lack of plausible, even reasonably humane, treatment resources for children and the realization that traditional mental health programs would probably not be developed because of expense and the shortage of manpower. The two initial sites chosen for replication were Memphis and Chattanooga. Plans for both schools included construction of a physical plant specifically designed for a Re-ED program. Staff were selected early enough to participate in a two month summer training program at Cumberland House, including work with children under the supervision of experienced teacher-counselors. The temporary influx of adults made it necessary to recruit additional children for a day program, creating an overcrowded and rather stressful situation for all concerned. To the extent possible, trainees were placed in the role they expected to assume in the new schools. Also to the extent possible, leadership roles for the new schools were assigned to persons with Re-ED training and experience in programs like Cumberland House. There was concern expressed at the time that

many of the new staff had not been through the Re-ED training program at Peabody but the time line did not allow the luxury of a year's graduate study. In contrast, the staff who opened Cumberland House had spent a year together in classes and seminars, planning programs and identifying roles and responsibilities. Vacant positions had been filled by graduates of that program until the replication began. However, the mix of the summer's training and experienced leadership seemed to have been adequate to the challenge of getting the two new schools organized and operating smoothly in the fall. Continuing consultation was provided by Central Office and Peabody staff and, as far as informal observation could determine, the new schools were preserving all the essential elements of a Re-ED program, in spite of rather different local resources and physical settings. Both were in new facilities, especially designed for a Re-ED program serving 35 to 40 children, living quarters and school and office space in a single building, more functional than the rennovated houses being used by Cumberland House at that time, but possibly with the disadvantage of appearing more institutional in character, particularly since both were located on the grounds of a mental health institute. Smallwood, the school in Chattanooga, is sufficiently distant from the rest of the hospital buildings to preserve a separate identity. The location of Sequoia, in Memphis, seemed problematic as it was in, in fact surrounded by, a huge medical complex including the training hospitals used by the University of Tennessee medical school. Not only was it a crowded, inner city setting with all that implies, but the medical-

psychiatric subcultural influences appeared to be pervasive and possibly overwhelming. However, the program proved resilient and was able to maintain its integrity.

A year or so after the two new children's programs were started, planning began for the first Re-ED adolescent program, Pine Breeze in Chattanooga. Here, the task was different. Rather than duplicating as accurately as possible what happened in a Re-ED school for children, the attempt was to extropolate the principles to work with a different age group with different, more difficult problems. The questions were endless and mostly unanswerable: "Can we use pow-wows? Will adult attention be reinforcing? How will we control aggressive outbursts and fighting? Won't they really be turned off about school?", etc. Having adolescent boys and girls in the same program was a special challenge, as was the physical setting, several old buildings, formerly housing a TB sanitarium, in a somewhat isolated location. Control of movement among buildings and of runaway behavior seemed difficult. As with the two earlier replications, experienced staff were assigned leadership roles, although with somewhat more responsibility for training of new staff. Fortunately, the timetable was more relaxed and the staff had several months to organize programs and training experiences for themselves before admitting the first adolescents. It is fair to report that the first few years were not easy. Teenagers are indeed bigger, stronger, and meaner than little kids. Motivation is different, bad habits have been practiced longer, more personal troubles need verbal expression, and sexual overtones are often

present. At one point, the staff declared a "time out" for themselves, closing the school for a week while they worked out some new directions and programming procedures to correct obvious faults. Though difficult, the upward extension of Re-ED principles worked effectively at Pine Breeze as they have in other adolescent programs in the years since.

Encouraged by the experience at Pine Breeze a second adolescent program in Knoxville, called Riverbend, was begun, with noticeably less confusion and pain, by restaffing and reorganizing an existing adolescent unit at the Institute. Leadership staff from Pine Breeze and intensive training experiences were introduced prior to the transition to a Re-ED program. Younger children were added later as the program stablized. Like Riverbend, the adolescent unit in Nashville, Crockett Academy, involved bringing experienced staff in key roles and training experiences into an existing program, although in a setting where a Re-ED program for children, Cumberland House, was already in operation. All three of these programs, Pine Breeze, Riverbend, and Crockett Academy provide daily assurance that Re-ED staffing and strategies may be translated into effective programs to serve adolescents.

One replication for adolescents was attempted and failed, at least as a Re-ED program, for organizational and administrative reasons. In Memphis, where the children's program had prospered in spite of its location in a large medical complex, an adolescent Re-ED unit was opened but without as much experienced leadership or training and consultation as had characterized other replications. Before the program had stabilized, a young enthusiastic

child psychiatrist was assigned administrative and supervisory responsibility for the adolescent unit and he began to shape the program and staffing in a more traditional direction. The unit continues to have an excellent school program, but the organization and staffing resemble that in a ward in a good mental hospital. A similar administrative change occurred in the children's unit but its momentum by that time was such that substantial alterations were not apparent in the day-to-day operation of the program.

One other program, where no replication was attempted, deserves comment. It is located in rural west Tennessee and for that reason it is difficult to attract and keep capable professional staff. Occasional consultation has been provided to an existing program for a number of years with some noticeable improvements and some superficial resemblance to a Re-ED program. Most of the staff are educators, teaching and learning are considered the most important business to be transacted, personal goals are set and evaluated regularly, etc.

Thus, there has been in operation for nearly ten years a state-wide network of residential treatment centers developed from the Re-ED model. The notable exception is the adolescent unit in Memphis. Parenthetically, it is the only program without a distinctive name, it is simply "the adolescent unit". Now called Child and Youth Services, the five programs serve about 250 students at any one time but because of the relatively short length of stay, between 800 and 900 persons are served in a year. More adolescents than children are served, two-thirds of the admissions are 14 or older. There are more boys than girls, about

two to one, and while that ratio is shaped by program organization, i.e., if a program has three boys' groups and two girls' groups, that will be reflected in admissions, each program has made an effort to respond to referral patterns in the region it serves. Virtually all of the referrals have had prior special education or outpatient mental health services, and more than one-third have had prior inpatient psychiatric treatment. That degree of seriousness of problems is not reflected, however, in admission diagnoses, two-thirds of which are adjustment reaction to childhood or adolescence or transient situational disturbance. Only ten percent of the admissions receive a diagnosis reflecting psychotic problems and another fifteen percent is accounted for by substance abuse and character disorders.

As if the challenge of transplanting ideas and techniques into new settings and into application with older students were not challenging enough, the affiliation with mental health institutes further tested the viability of the model. Serious thought had been given to Re-ED replication under the sponsorship of public education, and it has been done in some other states, but in Tennessee, education was not ready for that responsibility and the Department of Mental Health, in a sense, already had it and chose to incorporate the replications in its five institute programs. A mental health institute is basically a state psychiatric hospital and hospitals, as everyone knows, are run by doctors. That obviously posed a problem for a model designed to keep treatment responsibility in the hands of educators, with traditional mental health personnel in supporting, rather than

supervising, roles. The Re-ED replications serve as the inpatient psychiatric units for children and youth in the institutes. That means they are constrained in some important ways by State laws and institute policies that were written with the more traditional views of mental illness and hospital programs in mind. For example, each student must be examined on admission by a psychiatrist, given a DSM II diagnosis, and a physician must take legal responsibility for the course of his treatment. Consistency in organization and procedures have been maintained due to commitment of C & Y staff to the educational-behavioral-ecological model, and to some extent also because mental health professionals are scarce and expensive. They function as part time consultants, whatever their legal responsibilities may be, leaving day to day program operations in the hands of teacher-counselors. Again, the exception is the Memphis adolescent unit where direct supervisory responsibility has been given to mental health professionals.

The most serious, some may say challenging, consequence of the new institutional affiliation was responsibility for all persons under 18 admitted, committed, or transferred to the institute. The model Re-ED schools were able to be selective in their admissions and there were some fairly clear exclusion criteria based on a perception that some children might not be able to benefit from the program: mental retardation, serious psychosis, or even the judgment that a child might be too dangerous, either to himself or others, to be managed in a relatively open setting. That, of course, is not the case in a public psychiatric facility. The C & Y staff still control voluntary admissions, which are in the majority, but juvenile court judges may order a person to be

evaluated in a C & Y program (about 10% of the admissions statewide), the Department of Correction may transfer anyone they determine to be in need of mental health treatment (another 10%), civil courts may commit persons under 18 involuntarily, though they do so in very small numbers, and emergency admissions must be accepted. As a result, the population in C & Y programs is clearly more problematic than during the Re-ED days. Family interaction patterns are more discordant, there are more single parent families, more children who have no family at all, children who are more severely disturbed, more aggressive, who have more involvement with the juvenile justice system, and who on the average, function at lower intellectual and educational levels.

These demands produced stress on the model and some variations on the earlier themes - an intake group was used in two of the programs to deal with some of the special problems, separate groups for autistic and delayed children, co-ed groups, token economies, vocational training, business enterprises, etc. Not all variations have proved successful, but the fact that they can occur and that some of them were adopted as regular program components seem to support the notion that the model is resilient and can change to meet new needs and opportunities, as has also been demonstrated outside of Tennessee.

Two populations are still not as well served as we would like: the sometimes violent, often out of control, runaway prone teenager and the seriously delayed, usually retarded child or adolescent who is diagnosed as autistic or schizophrenic. In the first instance, the prevailing staffing patterns and physical

security do not allow sufficient control of violent and runaway behavior. Supervision is never constant, except when suicide precautions are being taken, seclusion rooms and restraints are used sparingly, and locked windows and doors are surprisingly vulnerable to those who are persistent and want to find a way out. Intermittent planning to improve our capability to manage that kind of problem better has so far not borne fruit. Unfortunately, most of the negative consequences are suffered by the students - often a return to, or commitment to, a Correction institution where no mental health treatment is available. Different approaches have been taken with autistic and other profoundly disturbed children - separate groups, one autistic child in a group of less disturbed children, a residential program with children attending public schools, and so on, but we have made no system-wide response. That is not to suggest that there are no violent or autistic children treated successfully, because there are, simply that we think there is a need for more specialized programs for these unusual problems.

An additional source of strain on the model came as a result of the need for C & Y programs to meet the standards of the Joint Commission on Accreditation of Hospitals and Federal regulations for Medicaid under 21, establishing and maintaining accreditation as inpatient psychiatric services for children for purposes of reimbursement. The Re-ED treatment philosophy, staffing pattern, and organization were, of course, designed as an alternative to psychiatric programs for children and while there are now doctors and nurses available, they are not as much in evidence as in more

traditional programs. So it was with some apprehension that the first JCAH surveys were anticipated. JCAH surveyors are mental health professionals, most often child psychiatrists, whose habitats are medical schools and psychiatric hospitals and clinics whose programs would often include educators or special educators in secondary roles, helping with but not directing treatment activities, like recreational therapists or other specialists in a hospital. As one would predict, the surveyors were initially a little surprised but, after observing and talking about the programs, made positive recommendations, though often with the proviso that mental health professionals should be more prominent. Medicaid under 21 reviewers were more problematic because of a special frame of reference problem. They were accustomed to reviewing general medical facilities and nursing homes, neither mental health nor children's programs, and their initial reaction was clear and negative. Comments like, "These are schools, not hospitals", were heard frequently during their visits. The problem was compounded when the State reviewers asked for consultation from the Federal Medicaid agency. Following a site visit to each program, the Federal consultant said, in effect, that even though they were accredited as inpatient psychiatric facilities for children, there was not enough participation by medical and mental health personnel to be eligible for Medicaid reimbursement. Fortunately, the Federal regulations for Medicaid under 21, while brief, are quite explicit on a number of points that are compatible with a Re-ED treatment model: An analysis of problems occurring in a child's natural behavior

settings must be made prior to admission and the treatment plan should reflect those problems, treatment objectives should be measurable and reviewed frequently, and plans for return to the community are to begin as soon as possible. That allowed us to argue, eventually with success, that while the programs didn't look much like hospitals, both the process and outcomes were consistent with the regulations and that reimbursement was appropriate. The principal organizational accommodation has been to add "legitimizing" staff, usually a psychiatrist and a clinical psychologist, on the occasions when the teacher-counselor teams meet to formulate and review treatment plans. Record-keeping related to Medicaid has been a continuing, and distracting, burden but the treatment model and its salutary effects on children have not been changed substantially by the imposition of these medical-psychiatric requirements.

Finally, a personal concern about the present status of the Re-ED model related to its success and durability. During the project days when the Re-ED schools were considered unusual and innovative, even daring, there was much uncertainty and continuous questioning about what programs and procedures were most appropriate and likely to be effective. Discussions were long and vigorous and answers, for the most part, were considered as hypotheses to be tested empirically. As the programs stabilized, so did the folklore about what worked well, and belief systems were communicated among staff members regarding techniques - pow wows, ecological maps, enterprise teaching, and so on - with a noticeable deceler-

ation in questioning the effectiveness of the procedures used. No doubt a steady stream of admiring visitors contributed to that, as did favorable mention in reports like that of the Joint Commission on Mental Health of Children, in textbooks on behavior disorders in children, and efforts at replication in other states. If approval from interested observers helped consolidate beliefs about treatment, then so did the organization of staff and students in Re-ED schools. A team of teacher-counselors working with a small group of children in a 24-hour program communicates frequently with each other, often with high emotional intensity, develops shorthand labels for familiar concepts and procedures, and responses to children's problems become institutionalized. Not institutionalized in a perjorative sense, but over a period of time, widely shared and highly valued beliefs and patterns of behavior of staff become difficult to change, even to question in any organization. That has its advantages, for example, imposing the Medicaid requirements on the Re-ED model did not change the basic character of the programs, but the possibility of institutional inertia may also leave a friendly skeptic wondering whether we are employing the best possible procedures available to us now in 1980. The last, and only large scale, systematic program evaluation was done in the late 1960's and limited to children from one program, Cumberland House, though with a remarkable array of measures and a very large sample. That two year follow-up study indicated quite clearly that children benefited from the treatment, but clients being served now are older, have more serious problems, and may be different in other ways we don't know about. There are still questions that need to be asked.

In any event, the innovation has survived multiple replications, a more challenging clientele, imposition of medical-psychiatric requirements, possibly some hardening of the arteries that seems to occur in all aging organisms, and to have become a part of the mental health establishment as the prevailing mode of providing residential treatment in Tennessee. We think that is a worthwhile accomplishment.